

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

7133

STATE FILE NUMBER

FILED AUG 23 1961

1. PLACE OF DEATH

a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only)

OR
TOWN

ST. LOUIS

Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

MISSOURI

b. COUNTY

admission)

c. CITY

OR
TOWN

ST. LOUIS

Inside Limits

Yes ☐ No ☐

c. FULL NAME OF (If NOT in hospital, give location)

HOSPITAL OR
INSTITUTION

HOMER G. PHILLIPS HOSP

Inside Limits

Yes ☐ No ☐

d. STREET

(If outside, give location)

1600 CARR DRIVE

Reside on Farm

Yes ☐ No ☐3. NAME OF DECEASED
(Type or print)

First

Middle

Last

PERLA

WILLIAMS

4. DATE
OF
DEATH

Month

Day

Year

JULY

31

618

5. SEX

FEMALE

6. COLOR OR RACE

NEGRO

7. Married ☒ Never Married ☒Widowed ☐ Divorced ☐

8. DATE OF BIRTH

8/14/1894

9. AGE (last birthday)

66

IF UNDER 1 YEAR IF UNDER 24 HR

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY

KANSAS

KANSAS

U.S.A.

12. CITIZEN OF WHAT COUNTRY

13a. FATHER'S NAME

UNKNOWN

13b. MOTHER'S MAIDEN NAME

UNKNOWN

14. NAME OF HUSBAND OR WIFE

ROBERT WILLIAMS

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no or unknown) NO

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

—

17. INFORMANT

Address

ROBERT WILLIAMS 1600 CARR DRIVE

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cerebral Vascular Accident

Conditions, if any,
which gave rise to
above cause (a),
stating the under-
lying cause last.

DUE TO (b)

Arterio Sclerosis.

DUE TO (c)

33/X

INTERVAL BETWEEN
ONSET AND DEATHPART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal
disease condition given in PART I (a)PART III. If deceased was female was
there a pregnancy in last 90 days.☐ Yes☐ N.☒ Unknown19. WAS AUTOPSY
PERFORMED?
YES ☐ NO ☒

20a. ACCIDENT

☐

SUICIDE

☐

HOMICIDE

☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF
INJURYHour
a.m.
p.m.

Month, Day, Year

20d. INJURY OCCURRED
WHILE AT WORK ☐
NOT WHILE AT WORK ☐20e. PLACE OF INJURY (e.g., in or about home,
farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from

830 - A

to

and last saw him

alive on

Death occurred at

830 - A

m

on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

22b. ADDRESS

22c. DATE SIGNED

23a. BURIAL, CREMATION,
REMOVAL (Specify)

REMOVAL

23b. DATE

8/4/61

23c. NAME OF CEMETERY OR CREMATORY

WASHINGTON PARK

23d. LOCATION (City, town, or county)

ST. LOUIS COUNTY

(State)

MO

24. FUNERAL DIRECTOR

ADDRESS

BOYD BROS 3706 FINNEY AVE

25. DATE RECD. BY LOCAL REG.

AUG 1 1961

26. REGISTRAR'S SIGNATURE

Rear Smith, M.D.

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed Henry C. Williams

Licensed Embalmer No. 4981

P. O. Address 1205 Walton

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.